PRINTED: 02/19/2018 FORM APPROVED

Health Regulation & Licensing Admini STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDENT		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A, BUILDING		
		ALR-0003	B, WING	01/31/2018	
NAME OF PROVIDER OR SUPPLIER STREET AD			DDRESS, CITY,	1 01/01/2010	
HE ME	THODIST HOME OF D	C- FOREST HILL 4901 CO	NNECTICUT	AVENUE NW	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE
R 000	Initial Comments		R 000		
	2018 to determine of Living Law "DC Cook Living Residence (A thirty-two (32) reside (19) employees to in administrative staff, and three (3) emplo The findings of the subservations, record residents and employees.	re abbreviations used		The practice at Forest Hills of DC to include all members of the interdisciplinary team in ISP meetings.	is
	ALR Assisted Living Residence ISP Individualized Service Plan			R 483 Failure to ensure physical there review of ISP.	ару
R 483	Sec. 604d Individual	zed Service Plans	R 483	Corrective action for affect resident.	ted
is so the second	admission and at lea The ISP shall be upd is a significant chang The resident and, if reshall be invited to part eassessment. The resident's healthcare he resident's healthcare he resident's surrogant LR. based on record review ailed to ensure the part he ISP for one (1) of ample, who was record review ample, who was record review and the sample in the part of th	eview shall be conducted by am that includes the practitioner, the resident, ate, if necessary, and the ew and interview, the ALR hysical therapist reviewed one (1) resident's in the eiving physical therapy		Resident #2's record reviewed and updated by Rehab Director 02/01/18 Rehab Director or design will attend care plans for resident as indicated.  2. Identification of others potentially affected by the same practice.  Record of all residents currently receiving rehab services reviewed. Rehat informed of date and time ISP for all residents who	nee
	ervices (Resident #2 Findings included:	).		were scheduled for ISP review.	

STATE FORM

executive Direct

(X6) DATE

If continuation sheet 1 of 2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVE COMPLETED		
		ALR-0003	B. WING		01/31/201		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE		71/	01/31/201	
	THODIST HOME OF D	WASHING	NNECTICUT A STON, DC 20	VENUE NW 008	25		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X COMF DA	
R 483	Review of Resident: 01/31/18 at 12:00 Pthad thirteen falls from November 11, 2017. minor injuries includit two skin tears from for Continued review of resident received phyeach fall. However, the showed that the Physit.  During an interview would not be a continued to the physit.  During an interview would not be a continued to the physit.  At the time of the sun all members of the interview of	#2's medical record on M showed that the resident m March 2, 2017 through The resident sustained ng an abrasion, a bruise, and our of the thirteen falls. the record showed that the ysical therapy services after he ISP dated 08/ 23/17 sical Therapist did not review with the Physical Therapist on she stated that she did not ISP.	R 483	3. Systemic change to deficient practice de recur.  Rehab Director wincluded on mont for residents who scheduled for ISF and also inform of time of meetings scheduled.  4. Performance monitor make the solution is sustained.  Assisted Living N Manager will mon meeting attendan therapy represent meetings for reside currently on rehability.	ill be hly emails are review f date and when  pring to  urse itor ISP ce to verify ation at		